THE SENTINEL
OFFICIAL SAFETY NEWSLETTER OF CIVIL AIR PATROL
*HQ CAP Chief of Safety, Gary K. Woodsmall – Jan 03 Edition*
***E-mail:*** gwoodsmall@capnhq.gov ***Phone: 334-953-5352***

**A Simple Lesson:** (View the trap as a hazard, safety violation or concern.)
A rat looked through a crack in the wall to see the farmer and his wife opening a package. What food might it contain? He was aghast to discover that it was a rat trap. Retreating to the farmyard, the rat proclaimed the warning; "There is a rat trap in the house, a rat trap in the house!" The chicken clucked and scratched, raised her head and said, "Excuse me, Mr. Rat, I can tell this is a grave concern to you, but it is of no consequence to me. I cannot be bothered by it." The rat turned to the pig and told him, "There is a rat trap in the house, a rat trap in the house!" "I am so very sorry Mr. Rat," sympathized the pig, "but there is nothing I can do about it but pray. Be assured that you are in my prayers." The rat turned to the cow. She said, "Like wow, Mr. Rat, a rat trap. I am in grave danger. Duh?" So the rat returned to the house, head down and dejected, to face the farmer's rat trap alone.

That very night a sound was heard throughout the house, like the sound of a rat trap catching its prey. The farmer's wife rushed to see what was caught. In the darkness, she did not see that it was a venomous snake whose tail the trap had caught. The snake bit the farmer's wife. The farmer rushed her to the hospital. She returned home with a fever. Now everyone knows you treat a fever with fresh chicken soup, so the farmer took his hatchet to the farmyard for the soup's main ingredient. His wife's sickness continued so that friends and neighbors came to sit with her around the clock. To feed them the farmer butchered the pig. The farmer's wife did not get well. She died, and so many people came for her funeral that the farmer had the cow slaughtered to provide meat for all of them to eat. So the next time you hear that someone is facing a problem and think that it does not concern you, remember that when there is a rat trap in the house, the whole farmyard is at risk.

**Reporting and Investigating CAP Mishaps:** Most CAP members are familiar with CAPR 62-2 and the requirements to report and investigate all CAP mishaps. However, lately I've seen several trends in reporting that can have serious effects on our mishap prevention efforts. But, before I describe these trends and ask for your help in turning them around, let me briefly review the process.

The process of reporting and investigating CAP mishaps is relatively straightforward and is laid out cookbook-style in CAPR 62-2. Probably the most challenging task is determining when an aircraft "incident" crosses the threshold to become an aircraft "accident" in the substantial damage category. The subtleties are found in CFR, Title 49, Chapter VIII, Part 830, which I have conveniently attached to CAPR 62-2. If you're ever in doubt about whether or not the damage is "substantial", contact the local FAA Flight Standards District Office and they will send out a representative to make the determination.

Immediate notification of accidents, which involve substantial damage, serious injury or death, has been greatly simplified with the 24 hour National Operations Center toll-free number – 888-211-1812. Notification for less serious mishaps should be accomplished within 48 hours of the mishap using the CAPF 78. The National Operations/Safety fax - 334-953-6342 - is probably the quickest way to submit these forms. For the most part, initial reporting is timely and accurate. However, some show up occasionally with incomplete information or a very vague description of the mishap. Probably the two most important pieces of information are the name of the person completing the report and their phone number, in case there are questions.

After notifying everyone that the mishap has happened, the real work begins. Now comes the investigation - interviews, photos, pilot and aircraft records, etc. Once the facts have been gathered, a thorough analysis must be conducted to produce the document that contributes most to mishap prevention, the CAPF 79, CAP Mishap Investigation Form. Unless directed otherwise by the CAP General Counsel, this document is required for all mishaps and is due 35 days after the mishap. As the report is written, the investigator should identify findings and causes. The International Society of Air Safety Investigators defines findings as "all significant conditions and events, causal and non-causal, found in the investigation." Findings are typically a list of the investigator's conclusions listed in chronological order. This logical progression of relevant events makes identifying causes much easier. Causes are findings, which singly or in combination with other causes, resulted in the damage or injury that occurred. A cause can be a deficiency, an act, an omission, a condition or a circumstance that either starts or sustains the mishap sequence.

The point of doing an investigation is to prevent the mishap from reoccurring by correcting the deficiencies that allowed it to happen in the first place. Start by examining the causes and asking how they might be prevented. Keep in mind that recommendations must be feasible and cost effective or they will never be adopted. Because of the feasibility and cost variables, the investigator might not be the best person to make recommendations. It's perfectly acceptable to bring in subject matter experts to develop a recommended course of action to reduce or eliminate the deficiencies that were identified. If recommendations originate solely from the investigator, the people charged with implementation should review them for practicality before the report is final.

So, where am I going with all of this? Well, first I wanted to review the importance of timely and quality mishap reporting. Additionally, I'd like to ask commanders and safety officers to help ensure that CAPF 79s are not only accomplished in a quality manner, but also that they are up-channeled as required in CAPR 62-2. In March of FY02, 15 CAPF 79s from 18 mishaps had not been received! At FY02 closeout, 33 out of 48 CAPF 79s were either completely missing or not coordinated through the region commander - nearly 70%. None of the ten FY03 CAPF 79s have yet been received! Without mishap follow-up, we can't adequately address the situations causing us problems. In short, these mishaps will continue to plague us, unless we turn this trend around.

***The 2003 Safety Pledge For All CAP Flying And Ground Activities:***

***I pledge to do my part to foster a safe environment during all CAP activities, to be a responsible steward of CAP resources and to fully prepare myself for the challenging missions that serve America.***